Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
	Women's / Maternal Health				
#1: Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age	a. Convene state and federal, public and private, managed care and fee for service payers to understand the landscape of patient centered medical homes for women with the potential for developing a strategy for expansion or enhancement. b. Collaborate with University of Illinois School of Public Health, Title X and Illinois Department of Healthcare and Family Services to develop and implement a pilot for Pediatricians/Family Practice doctors to offer women an opportunity to complete a reproductive health planning tool during the infant's well-baby visits. c. Improve navigation from prenatal care to postpartum care by supporting the roll out of the Illinois Department of Healthcare and Family Services' prenatal to postpartum care efforts and working with the OB-GYN, Family Medicine and Midwife professional organizations to expand to providers serving privately insured women. d. Support use of the IDHFS women-centered postpartum checklist brochure developed through IL CHIPRA by sharing the checklist with medical professional organizations, and program sites for WIC, Family Case Management, and Healthy Start. e. Provide training and support to home visiting providers, Healthy Start, WIC, Better Birth Outcomes, Family Case Management and other providers working with expectant and new mothers, to increase patient awareness of highly effective contraception, particularly post-partum Long-Acting Reversible Contraception (LARC). f. Collaborate with the Illinois Department of Healthcare and Family Services to develop training and support for healthcare providers to facilitate their ability to educate women and provide access to LARC.	ESM-1.1: Number of providers trained on the use of the postpartum care transition checklist developed through CHIPRA *(strategies 1-c, 1-d)*	NPM-1: % women with a past year preventive medical visit SPM-1: % Medicaid-enrolled women ages 21-44 using a most or moderately effective contraception method	NOM-1: % Births with prenatal care in the first trimester NOM-2: Severe maternal morbidity NOM-3: Maternal mortality rate NOM-4.1: LBW deliveries NOM-4.2: VLBW deliveries NOM-4.3: Moderately LBW deliveries NOM-5.1: Preterm births NOM-5.2: Early preterm births NOM-5.3: Late preterm births NOM-6: Early term births SOM-1: Chlamydia infection rate among women ages 15-24 SOM-2: Mental health and substance use hospitalizations to women ages 15-44	NPM-1: By 2020, increase the percent of women with a past-year preventive medical visit by at least 10% SPM-1: By 2020, increase the percent of women using most/moderately effective contraception by at least 10% NOM-2: By 2020, decrease the rate of severe maternal morbidity by at least 10% SOM-1: By 2020, reduce the rate of Chlamydia infections in women ages 15-24 by at least 10% SOM-2: By 2020, reduce the rate of inpatient hospitalizations for mental health and substance use among women ages 15-44 by at least 15%

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
	Perinatal / Infant Health				
#2: Support healthy pregnancies and improve birth and infant outcomes	a. Provide support to pregnant women at risk for poor birth outcomes through an array of case management and home visiting programs through the Illinois Dept of Human Services. Ensure IDHS MCH programs align with Title V priorities. b. Distribute information on topics related to health in pregnancy (e.g., oral health, smoking, and chronic disease management) to women through service providers (e.g., case management and home visiting providers) and social media (e.g., Facebook and Twitter). Utilize prenatal care materials from IL CHIPRA and leverage existing public awareness campaigns, such as Text4Baby. c. Explore creation of a portal for information and referrals to pre-/inter-conception health services and support for women who have had a prior adverse pregnancy or birth outcome. d. Provide home visiting services to families with newborns identified in the Adverse Pregnancy Outcome Reporting System (APORS) through the IDHS High-Risk Infant follow-up program. e. Support the Illinois Home Visiting Task Force in the design and implementation of the Universal Newborn Support System pilot, which will offer home visiting to every newborn and their family in Illinois to determine their support needs and refer them to appropriate services. f. Through CoIIN Safe Sleep workgroup, create/organize a safe sleep toolkit that provides educational information for public health professionals on ways to promote safe sleep and gives information to hospitals, home visiting agencies, childcares and other organizations on developing evidence-based safe sleep policies. g. Partner with the March of Dimes to implement the Healthy Babies are Worth the Wait public awareness campaign through distribution at all publicly funded perinatal sites (such as WIC, FCM, Healthy Start, etc.). h. Partner with the Illinois Quit Line and the Illinois Lung Association to implement a public awareness campaign to reduce smoking through the dissemination of pamphlets, handouts and other printed materials.	ESM-3.1: Implement a quality improvement initiative to increase the number of high-risk maternal transports to Level III or IV facilities prior to delivery ESM-13.1: Number of programs serving pregnant women provided with information about oral health during pregnancy ESM-14.1: Number of calls to the state QuitLine by persons living in a household with children under age 5	NPM-3: % Very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) NPM-13A: % Pregnant women who had their teeth cleaned NPM-14A: % Women smoking during pregnancy SPM-2: % infants placed to sleep on back	NOM-1: % Births with prenatal care in the first trimester NOM-2: Severe maternal morbidity NOM-3: Maternal mortality rate NOM-4.1: LBW deliveries NOM-4.2: VLBW deliveries NOM-4.3: Moderately LBW deliveries NOM-5.1: Preterm births NOM-5.2: Early preterm births NOM-5.3: Late preterm births NOM-6: Early term births NOM-7: Non-medically indicated elective deliveries NOM-8: Perinatal mortality NOM-9.1: Infant mortality NOM-9.2: Neonatal mortality	NPM-1: By 2020, increase the percent of women with a past-year preventive medical visit by at least 10% NPM-3: By 2020, increase the percent of VLBW babies born in Level III+ perinatal hospitals by at least 10% NPM-13A: By 2020, increase the percent of pregnant women who has their teeth cleaned during pregnancy by at least 10%. NPM-14A: By 2020, decrease the percent of women who smoke during pregnancy by at least 15%. SPM-2: By 2020, increase the percent of infants placed to sleep on back by at least 5% NOM-1: By 2020, increase the percent of women receiving prenatal care in the first trimester by at least 5%.

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
#2: Support healthy pregnancies and improve birth and infant outcomes *(continued)*	i. Maintain a strong system of regionalized perinatal care by supporting perinatal network administrators and outreach/education coordinators and identifying opportunities for improving the state system: i. Utilize the Levels of Care Assessment Tool (LOCATe) to describe neonatal and maternal levels of care in Illinois and inform improvements to Illinois' regionalized perinatal system. ii. Conduct a study of very preterm infants (<32 weeks) delivered outside Level III facilities to identify the reasons for no maternal or neonatal transport and the barriers to risk-appropriate care. iii. Develop a quality improvement initiative to increase the percentage of very preterm infants (<32 weeks) delivered in Level III facilities. iv. Update state Obstetric Hemorrhage Toolkit based on information in the ACOG Obstetric Hemorrhage Bundle and distribute updated educational and training materials to all Illinois hospitals. j. Review the state Maternal Mortality Review process and identify opportunities for improving efficiency in abstraction, data collection, and analysis. k. Conduct reviews of severe maternal morbidities through the regional administrative perinatal centers to determine causes and develop action plans. l. Collaborate with the Illinois Perinatal Quality Collaborative to implement quality improvement projects in birthing hospitals that will improve health outcomes, (e.g., statewide maternal hypertension project). m. Participate in IDPH Zika Action Team to develop state readiness plan emphasizing needs of MCH populations. Ensure public messaging includes information related to pregnancy prevention, distribute educational materials to partners, and support APORS in enhancing microcephaly surveillance. n. Support state breastfeeding initiatives, including promoting Baby-Friendly hospital designation and breast milk banks, evaluating the impact of the 2011 Illinois Breastfeeding Blueprint, and strategizing with HealthConnect One about breastfeeding program and policy development.	*See previous page*	*See previous page*	*(continued from previous page)* NOM-9.3: Post neonatal mortality NOM-9.4: Preterm-related mortality NOM-9.5: Sleep-related SUID death rate NOM-10: % Infants with fetal alcohol exposure in the last 3 months of pregnancy NOM-11: Neonatal abstinence syndrome rate NOM-12: Newborns screened for heritable disorders SOM-3: Black-white ratio of infant mortality rates (NOM-9.1)	*(continued from previous page)* SOM-3: By 2020, reduce the black-white ratio in infant mortality to no more than 2.0

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
#2: Support healthy pregnancies and improve birth and infant outcomes *(continued)*	o. Coordinate and support the state Neonatal Abstinence Syndrome (NAS) Advisory Committee by: i. Recommending committee membership and connecting partners to enhance multi-disciplinary committee ii. Presenting information about best practices for NAS prevention, treatment, and surveillance gleaned from other states and national partners iii. Reviewing, compiling, and analyzing data iv. Organizing the annual report due to the state legislature v. Implementing new data collection, reporting, and surveillance activities as required by HB1 (PA 99-0480)	*See previous page*	*See previous page*	*See previous page*	*See previous page*
Child Health					
#3: Support expanded access to and integration of early childhood services and systems	a. Work with the Governor's Office of Early Childhood Development and the Illinois Early Learning Council to create a comprehensive coordinated system for developmental screening, including social and emotional screens. Contribute to development of a quality improvement initiative and an environmental scan. b. Collaborate with the UIC Leadership and Education on Neurodevelopment and other Disabilities (LEND) program to train early childhood providers to conduct autism screening while conducting developmental and social-emotional screens. c. Participate on the Governor's Children's Cabinet and the Inter-Agency Team to facilitate coordination and synergy between the various early childhood systems. d. Provide training and support to home visiting and early childhood providers to encourage family literacy and healthy families through improved knowledge of early brain and child development and support of early literacy. e. Partner with the Illinois Early Learning Council to assist childcare providers with improving quality, phasing in quality rating systems, ensuring sufficient monitoring of health and safety, and improving infant-toddler care.	ESM-6.1: Conduct an environmental scan of developmental screening in Illinois	NPM-6: % Children (10-71 months) receiving a developmental screening using a parent-completed tool	NOM-13: % Children meeting the criteria developed for school readiness *(developmental)* NOM-17.3: % Children diagnosed with autism spectrum disorder NOM-17.4: % Children diagnosed with attention deficit disorder / attention deficit hyperactivity disorder (ADD/ADHD) NOM-19: % Children in excellent or very good health	NPM-6: By 2020, increase the percent of children under 5 years old who received a developmental screening using a parent-completed tool by at least 30%.

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
#4: Integrate services within patient-centered medical homes for all children, particularly for CSHCN	a. Work with F2F, DSCC Family Advisory Council and care coordinators, and MCH program staff to develop and disseminate information to educate parents about the components of a Medical Home. b. Utilize DSCC and IDPH websites and social media platforms to post information for families about the components of a medical home and high-quality care. c. Work with key stakeholders, including IDHFS, to develop training and support for pediatric healthcare providers about the components of a Medical Home, with a focus on encouraging family-centered, compassionate, culturally effective care. d. Collaborate with ICAAP and IDHFS to encourage implementation of medical homes for all children, especially for CYSHCN, through promotion of the AAP National Medical Home website, which includes resources for medical practices. e. Educate medical home providers to improve their understanding of community resources and their ability to connect families, particularly those of CYSHCN, to needed services. f. Conduct a focus group in partnership with the Illinois Head Start Association with health coordinators from Early Head Start programs around the state to explore issues in accessing medical homes. g. Improve asthma identification and support services, including education of families, referral of children with asthma to appropriate health care and social services, and care coordination through community-based partnerships (e.g., Chicago Childhood Asthma Initiative at UIC, IDPH Division of Chronic Disease). h. Engage school-based health centers in a quality improvement project related to asthma management and education of students and school staff. (Partnership with IDPH Division of Chronic Disease and American Lung Association). i. Collaborate with Illinois Department of Healthcare and Family Services to identify opportunities to link children's medical homes to dental homes and support integration of care. j. Financially support the IDPH Division of Oral Health to provide dental sealants to children without insurance.	ESM-11.1: Number of pediatric providers trained on medical home components and functions	NPM-6: % Children (10-71 mos) receiving a developmental screening using a parent-completed tool NPM-11: % Children (with and without special healthcare needs) who have a medical home NPM-13B: % Children who had a preventive dental visit in the last 12 mos NPM-14B: % Children who live in a household with someone who smokes SPM-3: % Children receiving family-centered medical care	NOM-14: % Children ages 1 to 17 who have decayed teeth or cavities in the last 12 months NOM-15: Child mortality rate NOM-18: % Children with a mental or behavioral health condition who received treatment or counseling NOM-19: % Children in excellent or very good health NOM-20: % Children and adolescents who are overweight or obese NOM-22.1-5: various vaccination measures SOM-4: Asthma hospitalization rate for children 0-5	NPM-6: By 2020, increase the percent of children under 5 who received a developmental screening using a parent-completed tool by at least 30%. NPM-11: By 2020, increase the percent of children with a medical home by at least 10%. NPM-13B: By 2020, increase the percent of children ages 1-17 who received at least one preventive dental visit in the last year by at least 5%. NPM-14B: By 2020, decrease the percent of children exposed to environmental tobacco smoke in the home by at least 15%. SPM-3: By 2020, increase the percent of children receiving family-centered care by at least 10% SOM-4:By 2020, reduce the asthma hospitalization rate for young children by at least 15%

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
	Adolescent Health				
#5: Empower adolescents to adopt healthy behaviors	a. Provide evidence-based teen pregnancy prevention education in school and after-school settings through contracted sites for the Teen Pregnancy Prevention – Primary (TPPP) program; Conduct evaluation of TPPP program and incorporate program changes to improve efficiency and adolescent health outcomes b. Use bonus payments (Title V funded) to incentivize School Based Health Centers (SBHC) to provide well visits, risk assessments, and appropriate referrals for follow-up care to adolescent patients. c. Partner with Title X to use bonus payments to incentivize School Based Health Centers to become adolescent friendly clinics that directly provide family planning services within the SBHC. d. Work with the Illinois Chapter of the American Academy of Pediatrics to encourage providers to adopt "adolescent-friendly" principles in their practice	ESM-10.1: Number of adolescent well visits provided by school-based health centers	NPM-10: % Adolescents (ages 12-17) with a preventive medical visit in the past year SPM-4: % High school students reporting they attempted suicide in the last year	NOM-16.1-3: Adolescent mortality rate, motor vehicle mortality rate, suicide rate NOM-19: % Children in excellent or very good health NOM-20: % Adolescents who are overweight or obese NOM-22.2-22.5: various vaccination measures SOM-1: Chlamydia infection rate among women ages 15-24 SOM-2: Mental health and substance use hospitalizations to women ages 15-44	NPM-12: By 2020, increase the percent of adolescents with a past-year preventive medical visit by at least 5%. SPM-4: By 2020, reduce the percent of adolescents who attempted suicide by at least 20% SOM-1: By 2020, reduce the rate of Chlamydia infections in women ages 15-24 by at least 10% SOM-2: By 2020, reduce the rate of inpatient hospitalizations for mental health and substance use among women ages 15-44 by at least 15%
#6: Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs	a. Work with LEND and other key stakeholders to develop appropriate messaging for parents focused on the transition of adolescents from pediatric to adult care. b. Continue coordination/collaboration efforts with local health departments, provider groups, HFS, Medicaid MCOs, F2F, and other community groups to address system barriers that prevent comprehensive transition planning for adolescents (particularly those with special healthcare needs). c. Co-sponsor the annual Transition Conference in rotating locations throughout Illinois, including participating on the planning committee and financially supporting attendance by DSCC youth and families receiving care coordination services.	ESM-12.1: Percent of school-based health centers incorporating transition readiness assessments into adolescent well visits	NPM-12: % Adolescents (with and without special health care needs) who received services necessary to make transitions to adult health care	NOM-17.2: % Children with special health care needs (CSHCN) receiving care in a well-functioning system	NPM-12: By 2020, increase the percent of youth with special healthcare needs who received comprehensive transition planning services by at least 10%.

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
#6: Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs *(continued)*	d. Provide training updates on Transition to DSCC care coordinators. e. Maintain Transition Tips and Tools materials on DSCC website, including linking with national health care transition resources at Got Transition's website. f. Provide information to the public on transition by posting planning/training opportunities on social media and giving presentations to community groups. g. Renew Action Learning Collaborative team efforts to implement the National Standards for Systems of Care for CYSHCN. h. Establish a baseline on state transition performance based on upcoming estimates from the 2015/16 National Survey of Children's Health; conduct in-depth analysis of new transition questions and comparison to other states. i. Partner with School-Based Health Centers, IDHFS (EPSDT) and AAP to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits, and to use a standardized transition tool (e.g., transition readiness assessment in Six Core Elements of Health Care Transition).	*See previous page*	*See previous page*	*See previous page*	*See previous page*
Children with Special Healthcare Needs					
See priority #4 : Medical Home (child health)	Illinois made a deliberate decision to develop strategies for medical home that address the unique needs of CSHCN, but also more broadly address medical home for all children in Illinois. The full list of strategies is available under priority #4 in the child health domain.	*See priority #4*			
See priority #6 : Transition (adolescent health)	Illinois made a deliberate decision to develop strategies for transition to adult healthcare that address the unique needs of YSHCN, but also more broadly address transition planning and services for all adolescents in Illinois. The full list of strategies is available under priority #6 in the adolescent health domain.	*See priority #6*			

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
	Cross-Cutting / Life Course				
#7: Assure that equity is the foundation of all decision-making; eliminate disparities in MCH outcomes	a. Support the development and implementation of the online Infant Mortality Health Equity Toolkit through CoIIN Social Determinants of Health workgroup b. Launch training on the use of the Infant Mortality Health Equity Toolkit to provide information and resources to local health departments and other organizations to incorporate an equity framework into planning c. Promote existing training resources on life course, health equity, and social determinants of health to members of boards/groups working on MCH issues d. Promote and train health services agencies, including internal program units within IDPH, to use the health equity assessment tool (developed by the Minnesota Department of Health). e. Expand OWHFS (IDPH) requirements for describing disparities in grants/proposals and require demonstration of how health equity guides decision-making and program planning. f. Engage IDPH Health Equity Team to provide training to local MCH programs/entities on the health equity approach and use of equity lens. g. Ensure that data reports produced by Title V describe relevant disparities (by geography, race/ethnicity, age, disability status, etc), and discuss potential root causes, implications, and recommendations for moving towards equity. h. Collaborate with Committee on Institutional Cooperation (CIC) and Big 10 universities on Health Equity-focused funding proposals supporting policy analysis and data collaboration. i. In pediatric healthcare provider training related to medical home *(see strategy 4-c)*, emphasize the importance of providing culturally-competent care and use of a health equity lens.	None (no NPM)	*Consider disparities (by race/ethnicity, age, CSHCN status, geography) in all NPM* SPM-3: % Children receiving family-centered medical care	*Consider disparities (by race/ethnicity, age, CSHCN status, geography) in all NOM* NOM-17.1: Percent children with special healthcare needs NOM-21: Children without health insurance SOM-3: Black-white ratio of infant mortality rates (NOM-9.1)	SPM-3: By 2020, increase the percent of children receiving family-centered care by at least 10% SOM-3: By 2020, reduce the black-white ratio in infant mortality to no more than 2.0

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
#8: Support expanded access to and integration of mental health services and systems for the MCH population.	a. Support training on trauma-informed care, motivational interviewing, and mental health first aid for public health and medical professionals through webinars, and other educational opportunities, for providers working with mothers, fathers, infants, children, including those with special healthcare needs and adolescents. b. Partner with the State Health Improvement Plan (SHIP) Behavioral Health Action Team to carry out statewide strategies including: i. Encouraging the creation of local behavioral health planning councils and the development of collaborative action plans. ii. Supporting routine psychosocial assessment in healthcare and MCH services. c. Support positive youth development activities in adolescent health programs, such as Teen Pregnancy Prevention –Primary (TPPP) program. d. Conduct death reviews for violence and substance-related maternal deaths through the Maternal Mortality Review Committee-Violent Deaths (MMRC-V); generate annual report that summarizes public health recommendations for preventing such deaths. e. Partner with the Illinois Children's Mental Health Partnership to develop and implement a model for children's mental health consultations for local health departments and other public and private providers in the public health and healthcare delivery system. f. Conduct analysis of data related to mental health and substance use among women of reproductive age to demonstrate burden and importance of issue; develop data reports to disseminate findings.	None (no NPM)	No NPM SPM-4: % High school students reporting they attempted suicide in the last year	NOM-10: Infants born with fetal alcohol exposure in the last 3 months of pregnancy NOM-11: Neonatal abstinence syndrome rate NOM-16.3: Adolescent suicide rate, ages 15-19 per 100,000 NOM-18: % Children with a mental or behavioral condition who received needed treatment or counseling SOM-2: Mental health and substance use hospitalizations to women ages 15-44	SPM-4: By 2020, reduce the percent of adolescents who attempted suicide by at least 20% NOM-18: By 2020, increase the percent of children with a mental health or behavioral health condition who received treatment or counseling by at least 10%. SOM-2: By 2020, reduce the rate of inpatient hospitalizations for mental health and substance use among women ages 15-44 by at least 15%

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
#9: Partner with consumers, families and communities in decision-making across MCH programs, systems and policies	a. Implement a Title V Family Advisory Council in each of the seven Illinois Public Health regions. b. Maintain DSCC Family Advisory Council. c. Empower families of CSHCN through trainings to advocate for their children's care and the importance of medical home and transition services. d. Leverage existing community and family coalitions, such as Healthy Start Family Councils and the Arc of Illinois, to obtain ongoing feedback on the health needs of women, children, families, and communities, and the strengths and weaknesses of current systems serving these populations. e. In pediatric healthcare provider training related to medical home *(see strategies 4-c through 4-e)*, emphasize provision of family-centered care and decision-making, and include family voices to share their experiences with pediatric care.	None (no NPM)	No NPM SPM-3: % Children receiving family-centered medical care	No NOM	SPM-3: By 2020, increase the percent of children receiving family-centered care by at least 10%
#10: Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure	a. Within IDPH OWHFS and Title V, implement a standardized data/statistics request system to manage and organize internal and external data requests. b. Develop data products (e.g., fact sheets, data briefs, surveillance reports) for a variety of audiences. c. Present findings of epidemiologic and other studies conducted by Title V and its partners at state and national meetings and conferences; publish in peer-reviewed journals or state morbidity and mortality review. d. Develop and implement data linkage plans for data sources relevant to MCH, including: vital records, hospital discharge, Medicaid claims, program data, etc. e. Support efforts to sustain improvements in birth certificate accuracy through partnership with the ILPQC and the IDPH Division of Vital Records. f. Partner with and support Illinois PRAMS to use innovative strategies for improving response rates, including public outreach, implementation of web-based survey, and introduction of incentives for survey respondents. g. Support the development and use of questions focused on the social determinants of health in state health surveys, such as PRAMS and BRFSS.	None (no NPM)	No NPM SPM-5: Score for access, utilization, and reporting of ten MCH data sources	No NOM	SPM-5: By 2021, increase the state score for access, analysis, and reporting of various MCH data sources to at least 27 (out of 30). By December 2016, implement a request process/system to organize data and analysis requests.

Priority Area	Strategies	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures	Performance Objectives
#10: Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure *(continued)*	h. Obtain access to vital records for out-of-state occurrences to Illinois residents for Title V staff, thus improving completeness of Illinois data on births and deaths i. Enhance e-Perinet data system (for perinatal hospital reporting of outcome data) to create ability to electronically upload patient data from medical records, thus reducing manual data entry burden. j. Maintain the CDC MCH epidemiology assignee position to strengthen scientific leadership and strategic plan for enhancing data capacity and infrastructure. k. Conduct regular "data team" meetings for internal OWHFS staff. l. Mentor graduate student interns and fellows in epidemiology, including GSEP and CSTE Fellows. m. Enhance training and workforce development opportunities for analytic staff. n. Obtain epidemiologic technical assistance from the MCH epidemiology program at the University of Illinois at Chicago School of Public Health through an intergovernmental agreement (IGA). o. Collaborate with other IDPH divisions, other state agencies, and external partners on data projects; Support the Illinois Perinatal Quality Collaborative with epidemiologic technical assistance. p. Foster collaboration between DSCC and the University of Illinois MCH Epidemiology Program to improve data systems and analyze data related to CSHCN programs and services. q. Collaborate with the Longitudinal Data System (LDS), a partnership of several state agencies and the Illinois State Board of Education (ISBE), to facilitate the sharing of information across state agencies to understand the characteristics and outcomes of children receiving early childhood services.	*See previous page*	*See previous page*	*See previous page*	*See previous page*